STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Post -Survey Revisit (PSR) to the Investigation of Complaint IN00084624 completed on 2/7/11. Complaint IN00084624- not corrected. Deficiencies related to the allegations are cited at F225, and F226 Survey dates: 3/16/11 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Survey team: Teresa Buske, RN /TC Mary Weyls, RN Laura Brashear, RN Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 18 Medicaid: 58 Other: 12 Total: 88 Sample: 12 These deficiencies also reflect state	F0000	Preparation and/or execution of this plan of correction, in general, or this corrective action in particular, does not constitute and admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on March 17, 2011 by Bev Faulkner, RN			

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F0225 SS=D	Based on record review and interview, the facility failed to ensure all alleged violations of physical abuse and/or misappropriation of resident property for 2 of 4 residents with allegations of physical abuse and/or misappropriation of their property (i.e. missing property) in a sample of 12; in that 1.) the allegations were not immediately reported to other officials (ISDH) and/or 2.) further potential abuse was not prevented during investigations as staff with allegations were allowed to work after the allegations were voiced by staff. (Residents A and B) . Findings include: 1. Review of Missing Property Report dated 3/12/11 on 3/16/11 at 1 p.m., indicated Resident B had identified $12 missing on 3/12/11 and had notified the facility staff of the missing money from her belongings on 3/12/11. The report indicated the resident stated the money went missing out of her drawer between 3/11/11 and 3/12/11. The report indicated the money had been replaced by the facility on 3/14/11. Interview of the Administrator on 3/16/11 at 12:10 p.m., indicated the allegation of misappropriation of resident property (i.e.	F0225	**F 225 Investigate/Report Allegations/Individuals** It is the intent of this facility to ensure all alleged violations of physical abuse and/or misappropriation of resident property are immediately reported to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of person allegation is against. **1. CORRECTIVE ACTION:**a. The allegation of Resident B's missing money was reported to ISDH on 03/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 03/18/11. The employee the allegation was made against should have been immediately suspended, even though it was immediately investigated by management staff at the time the allegation was voiced. There was no evidence of any tape used. **2. OTHERS IDENTIFIED:**There were no others identified. **3. SYSTEMS IN PLACE:**a. An in-service was held on 2/07/11 and 2/08/11 for all staff to educate on current policies and procedures for allegations of abuse. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse,	03/18/2011

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	missing money) of Resident B had not been reported to Indiana Department of Health (ISDH). 2. Review of "Compliment and Concern Form," dated 3/13/11, completed by staff person #1 indicated an allegation of Resident A's self release seat belt was taped closed with white medical tape on 3/13/11 by RN #2. Interview of Administrator on 3/16/11 at 12:45 p.m., indicated she was notified on 3/13/11 of allegation of Resident A's self release seat belt was taped together with medical tape by RN #2. The Administrator indicated RN #2 was not suspended after allegation and completed her shift on 3/13/11. The Administrator also indicated RN #2 worked 3/14/11. The Administrator also indicated the allegation had not been reported to ISDH. This deficiency was cited on 2/7/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00084624. 3.1-28(c) 3.1-28(d)		including: 1) protecting the resident by having a staff member remain with the resident, 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:**a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	

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F0225 SS=D		F0225	**F 225 Investigate/Report Allegations/Individuals** It is the intent of this facility to ensure all alleged violations of physical abuse and/or misappropriation of resident property are immediately reported to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of person allegation is against. **1. CORRECTIVE ACTION:**a. The allegation of Resident B's missing money was reported to ISDH on 03/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 03/18/11. The employee the allegation was made against should have been immediately suspended, even though it was immediately investigated by management staff at the time the allegation was voiced. There was no evidence of any tape used. **2. OTHERS IDENTIFIED:**There were no others identified. **3. SYSTEMS IN PLACE:**a. An in-service was held on 2/07/11 and 2/08/11 for all staff to educate on current policies and procedures for allegations of abuse. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse,	03/18/2011

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			including: 1) protecting the resident by having a staff member remain with the resident, 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:**a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	

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F0225 SS=D		F0225	**F 225 Investigate/Report Allegations/Individuals** It is the intent of this facility to ensure all alleged violations of physical abuse and/or misappropriation of resident property are immediately reported to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of person allegation is against. **1. CORRECTIVE ACTION:**a. The allegation of Resident B's missing money was reported to ISDH on 03/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 03/18/11. The employee the allegation was made against should have been immediately suspended, even though it was immediately investigated by management staff at the time the allegation was voiced. There was no evidence of any tape used. **2. OTHERS IDENTIFIED:**There were no others identified. **3. SYSTEMS IN PLACE:**a. An in-service was held on 2/07/11 and 2/08/11 for all staff to educate on current policies and procedures for allegations of abuse. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse,	03/18/2011

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			including: 1) protecting the resident by having a staff member remain with the resident, 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:**a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	

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F0226 SS=D	Based on record review and interview, the facility failed to implement written policies and procedures for abuse of residents and misappropriation of resident property for 2 of 4 residents with allegations of physical abuse and/or missing property in a sample of 12; in that 1.) the allegations were not immediately reported to other officials (ISDH) and/or 2.) further potential abuse was not prevented during investigations as staff with allegations were allowed to work after the allegations were voiced by staff. (Residents A and B) . Findings include: 1. Review of Missing Property Report dated 3/12/11 on 3/16/11 at 1 p.m., indicated Resident B had identified the $12 missing on 3/12/11 and had notified the facility staff of the missing money from her belongings on 3/12/11. The report indicated the resident stated the money went missing out of her drawer between 3/11/11 and 3/12/11. The report indicated the money had been replaced by the facility on 3/14/11. Interview of the Administrator on 3/16/11 at 12:10 p.m., indicated the allegation of misappropriation of resident property i.e. missing money of Resident B had not	F0226	**F 226 Develop/Implement Abuse/Neglect, ETC Policies** It is the intent of this facility to implement written policies and procedures for abuse of residents and misappropriation of resident property with allegations of physical abuse and/or missing property to immediately report to the ISDH and prevent further potential abuse during investigations including not allowing staff to work. **1. CORRECTIVE ACTION:** a. The allegation of Resident B's missing money was reported to ISDH on 3/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 3/18/11. **2. OTHERS IDENTIFIED:** There were no others identified. **3. SYSTEMS IN PLACE:** a. This facility performed inservices on 2/07/11 and 2/08/11 to all staff in the building. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse, including: 1) protecting the resident by having a staff member remain with the resident,	03/18/2011

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	been reported to Indiana Department of Health (ISDH). 2. Review of "Compliment and Concern Form," dated 3/13/11, completed by staff person #1 indicated an allegation of Resident A's self release seat belt was taped closed with white medical tape on 3/13/11 by RN #2. Interview of Administrator on 3/16/11 at 12:45 p.m., indicated she was notified on 3/13/11 of allegation of Resident A's self release seat belt was taped together with medical tape by RN #2. The Administrator indicated RN #2 was not suspended after allegation and completed her shift on 3/13/11. The Administrator also indicated RN #2 worked 3/14/11. The Administrator also indicated the allegation had not been reported to ISDH. Review of the facility's current policy and procedure titled "Abuse-Response to Suspected," dated 6/1/10, on 3/16/11 at 3 p.m., indicated "...Procedures...2. If the allegation is related to physical, verbal, or mental abuse of a resident, the Administrator , designee, or staff member present at the time of the allegation will take immediate steps to prevent further potential abuse while the investigation is in process. Based on the circumstances,		2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:** a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	

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	this may include: immediate separation of staff-resident, separation of residents, suspension of staff member (s), implementation of one-on-one observation of the resident(s) and other actions as deemed appropriate by the staff member in attendance. 3. The Administrator or designee shall gather as much information as possible to determine whether there is reasonable cause to believe an event has occurred. If reasonable cause exists to believe an event occurred, the Administrator is responsible to report to the Indiana State Department of Health as per reporting guidelines. 4. The Administrator or designee will notify the resident's representative , and any State or Federal agencies of allegations per the Indiana State Department of Health Reporting guidelines...7. If the suspected perpetrator is an employee of the facility, he/she will be immediately suspended until the investigation has been completed or otherwise in accordance with employee policies..." Review of the facility's current policy and procedure titled "Reportable Unusual Occurrences," dated 6/1/10 on 3/16/11 at 3 p.m., indicated "...Procedures: Occurrences to be reported: Facilities are required by law to report unusual			

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	occurrences within 24 hours of occurrence to the Long Term Care Division. CFR 483. 13(c)(2) states that 'the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including State Survey and Certification Agency)'. " This deficiency was cited on 2/7/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00084624. 3.1-28(a)			

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F0226 SS=D		F0226	**F 226 Develop/Implement Abuse/Neglect, ETC Policies** It is the intent of this facility to implement written policies and procedures for abuse of residents and misappropriation of resident property with allegations of physical abuse and/or missing property to immediately report to the ISDH and prevent further potential abuse during investigations including not allowing staff to work. **1. CORRECTIVE ACTION:** a. The allegation of Resident B's missing money was reported to ISDH on 3/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 3/18/11. **2. OTHERS IDENTIFIED:** There were no others identified. **3. SYSTEMS IN PLACE:** a. This facility performed inservices on 2/07/11 and 2/08/11 to all staff in the building. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse, including: 1) protecting the resident by having a staff member remain with the resident,	03/18/2011

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			2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:** a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	

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F0226 SS=D		F0226	**F 226 Develop/Implement Abuse/Neglect, ETC Policies** It is the intent of this facility to implement written policies and procedures for abuse of residents and misappropriation of resident property with allegations of physical abuse and/or missing property to immediately report to the ISDH and prevent further potential abuse during investigations including not allowing staff to work. **1. CORRECTIVE ACTION:** a. The allegation of Resident B's missing money was reported to ISDH on 3/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISDH on 3/18/11. **2. OTHERS IDENTIFIED:** There were no others identified. **3. SYSTEMS IN PLACE:** a. This facility performed inservices on 2/07/11 and 2/08/11 to all staff in the building. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff on the requirements according to the Policy/Procedure for Abuse, including: 1) protecting the resident by having a staff member remain with the resident,	03/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). **4. MONITORING:** a. The Administrator/Director of Nursing will review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. This will be an on-going QA process. B. The Administrator/Designee will review all allegations of abuse with the Medical Director in the quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.**	